

PATIENT HISTORY FORM

TODAY'S DATE ____ / ____ / ____

DATE OF LAST PHYSICAL EXAM: ____ / ____ / ____

NAME _____ DATE OF BIRTH ____ / ____ / ____
LAST FIRST MI

CHIEF COMPLAINT – PAINFUL AREA _____

WHEN DID YOUR PROBLEM START? _____

DID IT START WITH AN INJURY? Y / N

DESCRIBE THIS INJURY _____

DESCRIBE ANY PRIOR INJURIES TO THE SAME AREA. _____

SINCE IT BEGAN THE PROBLEM HAS ...

WORSENER STAYED THE SAME IMPROVED RESOLVED

DESCRIBE THE PAIN ... (Please circle **all** that apply)

CONSTANT or INTERMITTANT

MILD – MODERATE – SEVERE

WORSENS OR IMPROVES WITH ACTIVITY

SHARP—DULL--BURNING—ELECTRICAL--PRESSURE—STIFF--HEAVY--WEAK

THIS PROBLEM PREVENTS

SLEEPING

WORKING

DRIVING

PLAYING SPORTS

NONE OF THE ABOVE

WHAT SEEMS TO MAKE IT BETTER

CERTAIN POSITIONS

ICE

HEAT-WARMTH

SLEEPING

MOVEMENT

MEDICATION

REST

WHAT SEEMS TO MAKE IT WORSE

CERTAIN POSITIONS

MOVEMENT

RUNNING

STAIRS

KNEELING or SQUATTING

PRESSURE

OTHER _____

MEDICAL HISTORY

ALLERGIES TO MEDICATIONS _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING 1) _____ 2) _____

3) _____ 4) _____ 5) _____ 6) _____

7) _____ 8) _____ 9) _____ 10) _____

PLEASE NOTE ANY THAT APPLY TO YOU (Please circle **check** that apply)

HEART DISEASE ()

HEART ATTACK / M.I. ()

HEART SURGERY ()

PACEMAKER ()

ON BLOOD THINNER ()

CANCER ()

DISABLED ()

KIDNEY PROBLEMS ()

ULCERS ()

INTESTINE PROBLEMS ()

LIVER DISEASE ()

DIABETES ()

RADIAION THERAPY ()

FIBROMYALGIA ()

HIGH BLOOD PRESSURE ()

RECENT SURGERY ()

ON ANTIBIOTICS ()

CHEMOTHERAPY ()

CHRONIC INFECTIONS ()

BLEEDING DISORDERS ()

ALCOHOL-DRUG PROBLEMS ()

DO YOU SMOKE ? Y / N

HOW MANY PACKS PER DAY ? _____

PLEASE LIST ANY MAJOR SURGERIES _____

* WHICH OF THESE TESTS DID YOU BRING WITH YOU? X-rays MRI CATscan BONE scan EMG

